Erratum


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Available online 29 June 2007

The publisher regrets that in the above article the word percutaneous was incorrectly spelled. The paragraphs containing the errors are reprinted below.

Before the development of percutaneous balloon aortic valvuloplasty, surgical valvotomy was the mainstay of treatment of critical aortic stenosis in neonates and infants. Different approaches such as trans-ventricular closed aortic valvotomy, open valvotomy with inflow occlusion or with cardiopulmonary bypass (CPB) were developed [1,4,5,32—37]. With improved safety of CPB and myocardial protection, open valvotomy with CPB became the preferred technique by almost all surgeons. The advantage of open valvotomy is that it allows detailed examination of the valve and accurate valvotomy; the disadvantages include the surgical morbidity and increased complexity of future surgery due to redo sternotomy. Although percutaneous balloon aortic valvuloplasty has replaced surgery to become the preferred technique in most centers, surgical valvotomy remains favored by some. Several risk factors for increased operative mortality have been identified including the presence of endocardial fibroelastosis, presence of hypoplastic left ventricle, or aortic annulus, presence of associated cardiovascular anomalies, extremely small neonates and earlier era surgery [2,5,33].

Since the first report of successful percutaneous balloon aortic valvuloplasty (BAVP) for aortic stenosis in infancy, this modality has become the favored technique in many institutions. Vascular access is usually obtained with an antegrade approach using the umbilical or the femoral arteries. However, retrograde approach using the carotid artery has been described [40,41]. In a report comparing retrograde and antegrade balloon aortic valvuloplasty, antegrade approach was associated with diminished morbidity compared with retrograde approach [40,41]. Advantages of percutaneous intervention include the avoidance of surgical morbidity associated with cardiopulmonary bypass. Disadvantages include vascular access complications, inability to precisely determine where the leaflets will tear and subsequent potential for aortic valve insufficiency, and rarely mitral valve injury [41]. It should be recognized that it is important not to overdilate the valve and that the goal is not complete elimination but improvement of the gradient until the patient is older and bigger, at which point the procedure can be repeated.

The publisher apologizes for this oversight.